

Introduction

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules* (MARFS), Provider Bulletins and Provider Updates. If there are any services, procedures or text contained in the physicians' Current Procedural Terminology (CPT®) and federal Healthcare Common Procedure Coding System (HCPCS) coding books that are in conflict with MARFS, the department's rules and policies take precedence (WAC 296-20-010). All policies in this manual apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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GENERAL INFORMATION

EFFECTIVE DATE

This edition of the *Medical Aid Rules and Fee Schedules* (MARFS) is effective for services performed on or after July 1, 2006.

UPDATES AND CORRECTIONS TO THE FEE SCHEDULES

If necessary, corrections to MARFS will be published on the department's web site at <http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2006/Updates2006.asp> under Fee Schedules/Updates & Corrections.

Additional fee schedule and policy information is published throughout the year in the department's Provider Bulletins and Provider Updates that are available at <http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp>.

Providers may join the L&I Medical Provider News electronic mailing list at <http://www.lni.wa.gov/Main/Listservs/Provider.asp>.

You will receive via e-mail:

- Updates and changes to the Medical Aid Rules and Fee Schedules.
- A link to the new Provider Bulletins as soon as they are posted.

STATE AGENCIES' FEE SCHEDULE AND PAYMENT POLICY DEVELOPMENT

The Washington State government payers coordinate fee schedule and payment policy development. The intent of this coordination is to develop payment systems and policies that make billing and payment requirements as consistent as possible for providers.

The state government payers are:

- The Washington State Fund Workers' Compensation Program (The State Fund) administered by the Department of Labor and Industries (L&I).
- The Uniform Medical Plan administered by the Health Care Authority (HCA) for state employees and retirees.
- The State Medicaid Program administered by the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS).

These agencies comprise the Interagency Reimbursement Steering Committee (RSC). The RSC receives input from the State Agency Technical Advisory Group (TAG) on the development of fee schedules and payment policies. The TAG consists of representatives from almost all major state professional provider associations.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own source of funding, benefit contracts, rates and conversion factors.

HEALTH CARE PROVIDER NETWORKS

The Revised Code of Washington (RCW) and the Washington Administrative Code (WAC) allow the department and self-insured employer (insurer) to recommend particular providers or to contract for services, but the choice of practitioner is the responsibility of the injured worker. RCW 51.04.030 (2) allows the insurer to recommend to the injured worker particular health care services or providers where specialized or cost-effective treatment can be obtained. However, RCW 51.28.020 and RCW 51.36.010 stipulate that the injured worker is to receive proper and necessary medical and surgical care from licensed practitioners of his or her choice.

MAXIMUM FEES NOT MINIMUM FEES

The department establishes maximum fees for services; it does not establish minimum fees. RCW 51.04.030 (2) states that the department shall, in consultation with interested persons, establish a fee schedule of maximum charges. This same RCW also stipulates that no service shall be paid at a rate or rates exceeding those specified in such fee schedule. WAC 296-20-010(2) reaffirms that the fees listed in the fee schedule are maximum fees.

BECOMING A PROVIDER

WORKERS' COMPENSATION PROGRAM

A provider must have an active L&I provider account number to receive payment for treating a Washington injured worker. All L&I providers must comply with all applicable state and/or federal licensing or certification requirements to assure providers are qualified to perform services. This includes state or federal laws pertaining to business and professional licenses as they apply to the specific provider's practice or business.

Providers can apply for account numbers by completing a Provider Account Application (form F248-011-000) and Form W9 (form F248-036-000). These forms are available at <http://www.LNI.wa.gov/ClaimsIns/Providers/Become/default.asp> or can be requested by contacting the department's Provider Accounts section or the Provider Hotline.

Contact Information

Provider Accounts

Department of Labor & Industries
PO Box 44261
Olympia, WA 98504-4261
360-902-5140

Provider Hotline

1-800-848-0811

More information about the provider application process is published in WAC 296-20-12401 which can be found in the Medical Aid Rules section at

CRIME VICTIMS COMPENSATION PROGRAM

A provider treating victims of crime must apply for a separate provider account with the Crime Victims Compensation Program. Provider Applications (form F800-053-000) and Form W9 (form F800-065-000) for the Crime Victims Compensation Program are available on the department's web site at <http://www.LNI.wa.gov/ClaimsIns/CrimeVictims/FormPub/default.asp> or can be requested by contacting the Crime Victims Compensation Program.

Contact Information

Crime Victims Compensation Program

Provider Registration
Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
1-800-762-3716

BILLING INSTRUCTIONS AND FORMS

BILLING PROCEDURES

Billing procedures are outlined in WAC 296-20-125 which can be found in the Medical Aid Rules section at <http://www.LNI.wa.gov/ClaimsIns/Rules/MedicalAid/default.asp>.

BILLING MANUALS AND BILLING INSTRUCTIONS

The *General Provider Billing Manual* (publication F248-100-000) and the department's provider specific billing instructions contain billing guidelines, reporting and documentation requirements, resource lists and contact information. These publications can be requested from the department's Provider Accounts section or the Provider Hotline. (Refer to Becoming a Provider for contact information.)

BILLING FORMS

Providers must use the department's most recent billing forms. Using out-of-date billing forms may result in delayed payment. To order new billing forms or other department publications, complete the Medical Forms Request (located under Contact Information on the MARFS CD or on the department's web site at <http://www.LNI.wa.gov/forms/pdf/208063a0.pdf>) and send it to the department's warehouse (address listed on the form).

GENERAL BILLING TIPS



This symbol is placed next to billing tips throughout the policy sections to facilitate correct payments.

SUBMITTING CLAIM DOCUMENTS TO THE STATE FUND

Mailing State Fund bills, reports and correspondence to the correct addresses helps the department pay you promptly.



Attending providers have the ability to send secure messages through the Claim and Account Center at <http://www.lni.wa.gov/ORLI/LoGon.asp>. Attending providers can also submit the Time Loss Notification (TLN) form as an e-transaction. When attending providers submit the TLN by an e-transaction they can bill for submission of the TLN form.

Item	FAX Numbers	State Fund Mailing Address
Report of Industrial Injury or Occupational Disease – Accident Report F242-130-000	ROAs ONLY (360) 902-6690 (800) 941-2976	Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299
Correspondence, reports and chart notes for State Fund Claims and claim related documents other than bills.	(360) 902-4292 (360) 902-4565 (360) 902-4566 (360) 902-4567 (360) 902-5230 (360) 902-6100 (360) 902-6252 (360) 902-6440	Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291 Reports and chart notes must be mailed separately from bills.
State Fund Provider Account information updates	(360) 902-4484	Department of Labor & Industries PO Box 44261 Olympia, WA 98504-4261
UB-92 Forms CMS 1500 Forms Retraining & Job Modification Bills Home Nursing Bills Miscellaneous Bills Pharmacy Bills Compound Prescription Bills Requests for Adjustment		Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
State Fund Refunds (attach copy of remittance advice)		Cashier's Office Department of Labor & Industries PO Box 44835 Olympia, WA 98504-4835

TIPS FOR SUBMITTING DOCUMENTS TO THE STATE FUND

The State Fund uses an imaging system to store electronic copies of all documents submitted on injured workers' claims. This system cannot read some types of paper and has difficulty passing other types through automated machinery.

Do's

Following these tips can help the department process your documents promptly and accurately.

- Submit documents on white 8 ½ x 11- inch paper (one-side only).
- Leave ½ inch at the top of the page blank.
- Submit legible information.
- Put the patient's name and claim number in the upper right hand corner of each page.
- If there is no claim number available, substitute the patient's social security number.
- Emphasize text using asterisks or underlines.
- Staple together all documents pertaining to one claim.
- Include a key to any abbreviations used.
- Reference only one worker/patient in a narrative report or letter.

Don'ts

Please do not submit information in the following manner.

- Don't use colored paper, particularly hot or intense colors.
- Don't use thick or textured paper.
- Don't send carbonless paper.
- Don't use any highlighter markings.
- Don't place information within shaded areas.
- Don't use italicized text.
- Don't use paper with black or dark borders, especially on the top border.
- Don't staple documents for different workers/patients together.

Following the above tips can prevent significant delays in claim management and bill payment and can help you avoid department requests for information you have already submitted.

DOCUMENTATION REQUIREMENTS

Providers must maintain documentation in workers' individual records to verify the level, type and extent of services provided to injured workers. The insurer may deny or reduce a provider's level of payment for a specific visit or service if the required documentation is not provided or the level or type of service does not match the procedure code billed. No additional amount is payable for documentation required to support billing.

In addition to the documentation requirements published by the American Medical Association (AMA) in the CPT® book, the insurer has additional reporting and documentation requirements. These requirements are described in the provider specific sections of this document (MARFS) and in WAC 296-20-06101. The insurer may pay separately for specialized reports or forms required for claims management. For specific documentation requirements see **Appendix H**.

RECORD KEEPING REQUIREMENTS

As a provider with a signed agreement with the department, you are the legal custodian of the injured worker's records. You must include subjective and objective findings, records of clinical assessment (diagnoses), reports, interpretations of x-rays, laboratory studies and other key clinical information in patient charts.

Providers are required to keep all records necessary for the department to audit the provision of services for a minimum of five years (See WAC 296-20-02005).

Providers are required to keep all x-rays for a minimum of ten years (See WACs 296-20-121 and 296-23-140). See WACs at <http://www.LNI.wa.gov/ClaimsIns/Rules/MedicalAid/default.asp>

CHARTING FORMAT

For progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, Plan and progress) format. In worker's compensation there is a unique need for work status information. To meet this need it is suggested adding **ER** to the SOAP contents. Chart notes must document employment issues, including a record of the patient's physical and medical ability to work, and information regarding any rehabilitation that the worker may need to undergo. Restrictions to recovery, any temporary or permanent physical limitations, and any unrelated condition(s) that may impede recovery must be documented.

"SOAP-ER" CHARTING FORMAT

Doctor's office/chart/progress notes and 60-day narrative reports should include the SOAP contents:

S Worker's Subjective complaints

What the worker states, or what the employer, co-worker or significant other (family, friend) reports, about the illness or injury. (Refer to WAC 296-20-220, j.)

O Doctor's Objective findings

What is directly observed and noticeable by the medical provider. This includes factual information, e.g., physical exam, lab tests, x-rays, etc. (Refer to WAC 296-20-220, i.)

A Doctor's Assessment

What conclusions the medical provider makes after evaluating all the subjective and objective information. These conclusions may appear as a definite diagnosis (dx.), a "Rule/Out" diagnosis (R/O), or simply as an impression. This also can include the etiology (ET), defined as the origin of the diagnosis; and/or prognosis, defined as being a prediction of the probable course or a likelihood of recovery from a disease and/or injury.

P Doctor's Plan and Progress

What the provider recommends as a plan of treatment. This is a goal directed plan based on the assessment. The goal must state what outcome is expected from the prescribed treatment and the plan must state how long the treatment will be administered.

As a Worker's Compensation insurer, the State Fund has unique needs for work status information. To meet this need, we suggest adding "**ER**" to the SOAP contents:

E Employment issues

Has the worker been released or returned to work? Is the patient currently working, and if so, at what job? When is release anticipated?

R Restrictions to recovery

Describe the physical limitations, both temporary and permanent, that prevent return-to-work. What other limitations, including unrelated conditions, are preventing return-to-work? Can the worker perform modified work or different duties while recovering (including transitional, part-time, or graduated hours)? Is there a need for return-to-work assistance?

OVERVIEW OF PAYMENT METHODS

HOSPITAL INPATIENT PAYMENT METHODS

The following is an overview of the department's payment methods for services in the hospital inpatient setting. See the [Facility Services section](#), page 153, or refer to Chapter 296-23A WAC at <http://www.LNI.wa.gov/ClaimsIns/Rules/MedicalAid/default.asp> for more information.

Self-insurers (see WAC 296-23A-0210)

Self-insurers use POAC to pay for all hospital inpatient services.

All Patient Diagnosis Related Groups (AP-DRG)

The department uses All Patient Diagnosis Related Groups (AP-DRGs) to pay for most inpatient hospital services.

Per Diem

The department uses statewide average per diem rates for five AP-DRG categories: chemical dependency, psychiatric, rehabilitation, medical and surgical. Some hospitals are paid for all inpatient services using per diem rates. Hospitals paid using the AP-DRG method are paid per diem rates for AP-DRGs designated as low volume.

Percent of Allowed Charges (POAC)

The department uses a POAC payment method for some hospitals that are exempt from the AP-DRG payment method.

The department uses the POAC as part of the outlier payment calculation for hospitals paid by the AP-DRG.

HOSPITAL OUTPATIENT PAYMENT METHODS

The following is an overview of the department's payment methods for services in the hospital outpatient setting. Refer to Chapter 296-23A WAC in the Medical Aid Rules and the Facility Services section for more detailed information.

Self-insurers (see WAC 296-23A-0221)

Self-insurers pay for radiology, pathology, laboratory, physical therapy and occupational therapy services according to the maximum fees in the Professional Services Fee Schedule.

Self-insurers use POAC to pay for hospital outpatient services that are not paid with the Professional Services Fee Schedule.

Ambulatory Payment Classifications (APC)

The department pays for most hospital outpatient services with the Ambulatory Payment Classifications (APC) payment method.

Professional Services Fee Schedule

The department pays for most services not paid with the APC payment method according to the maximum fees in the Professional Services Fee Schedule.

Percent of Allowed Charges (POAC)

Hospital outpatient services that are not paid with the APC payment method, the Professional Services Fee Schedule or by department contract are paid by a POAC payment method.

AMBULATORY SURGERY CENTER PAYMENT METHODS

Ambulatory Surgery Center (ASC) Groups

The insurers use a modified version of the ASC Grouping system that was developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC. Refer to Chapter 296-23B WAC in the Medical Aid Rules and the Facility Services section for more information.

By Report

The insurers pay for some covered services on a by report basis as defined in WAC 296-20-01002. Fees for By Report services may be based on the value of the service as determined by the report.

Max Fees

The department establishes rates for some services that are not priced with other payment methods.

PAIN MANAGEMENT PAYMENT METHODS

Chronic Pain Management Program Fee Schedule

The department pays for Chronic Pain Management Program Services using an all inclusive, phase-based, per diem fee schedule.

RESIDENTIAL FACILITY PAYMENT METHODS

Self-insurers

Self-insurers use negotiated rates to pay for all residential facility services.

Boarding Homes and Adult Family Homes

The department uses per diem fees to pay for medical services provided in Boarding Homes and Adult Family Homes.

Nursing Homes and Transitional Care Units

The department uses modified Resource Utilization Groups (RUGs) to develop daily per diem rates to pay for Nursing Home Services.

PROFESSIONAL PROVIDER PAYMENT METHODS

Resource Based Relative Value Scale (RBRVS)

The insurers use the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. More information about RBRVS is contained in the Professional Services section. Services priced according to the RBRVS fee schedule have a fee schedule indicator of R in the Professional Services Fee Schedule.

Anesthesia Fee Schedule

The insurers pay for most anesthesia services using anesthesia base and time units. More information is available in the Professional Services section.

Pharmacy Fee Schedule

The insurers pay pharmacies for drugs and medications according to the pharmacy fee schedule. More information is available in the Professional Services section.

Average Wholesale Price (AWP)

The department's rates for most drugs dispensed from a prescriber's office are priced based on a percentage of the AWP of the drug. Drugs priced with an AWP method have "AWP" in the Dollar Value columns and a "D" in the fee schedule indicator column of the Professional Services Fee Schedule.

Clinical Laboratory Fee Schedule

The department's clinical laboratory rates are based on a percentage of the clinical laboratory rates established by CMS. Services priced according to the department's clinical laboratory fee schedule have a fee schedule indicator of "L" in the Professional Services Fee Schedule.

Flat Fees

The department establishes rates for some services that are not priced with other payment methods. Services priced with flat fees have a fee schedule indicator of "F" in the Professional Services Fee Schedule.

Department Contracts

The department pays for some services by contract. Some of the services paid by contract include transcutaneous electrical nerve stimulator (TENS) units and supplies, utilization management and chemically related illness center services. Services paid by department agreement have a fee schedule indicator of "C" in the Professional Services Fee Schedule.

The Crime Victims Compensation Program does not contract for these services.

Please refer to the appropriate Provider Bulletin for additional information. Current Provider Bulletins and Provider Updates can be found at

<http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp>.

By Report

The insurers pay for some covered services on a by report basis as defined in

WAC 296-20-01002. Fees for By Report services may be based on the value of the service as determined by the report. Services paid by report have a fee schedule indicator of N in the Professional Services Fee Schedule and BR in other fee schedules.

BILLING CODES AND MODIFIERS

The department's fee schedules use the federal HCPCS and agency unique local codes.

NOTE: The fee schedules do not contain descriptions of the CPT® codes, and they do not contain full text descriptions of HCPCS or CDT codes. Providers must bill according to the full text descriptions published in the CPT® and HCPCS books, which can be purchased from private sources. Refer to WAC 296-20-010(1) for additional information.

HCPCS Level I codes are the CPT® codes that are developed, updated and copyrighted annually by the AMA. There are three categories of CPT® codes:

CPT® Category I codes are codes used for professional services and pathology and laboratory tests. These services are clinically recognized and generally accepted services, not newly emerging technologies. These codes consist of five numbers (e.g., 99201).

CPT® Category II codes are optional codes used to facilitate data collection for tracking performance measurement. These codes consist of four numbers followed by the letter "F" (e.g., 0001F).

CPT® Category III codes are temporary codes used to identify new and emerging technologies. These codes consist of four numbers followed by the letter "T" (e.g., 0001T).

HCPCS Level I modifiers are the CPT® modifiers that are developed, updated and copyrighted annually by the AMA. CPT® modifiers are used to indicate that a procedure or service has been altered without changing its definition. These modifiers consist of two numbers (e.g., -22). ***The department does not accept the five digit modifiers.***

HCPCS Level II codes, commonly called HCPCS (pronounced Hick-Picks), are updated annually by CMS. CMS develops most of the codes. Codes beginning with D are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3). HCPCS codes are used to identify miscellaneous services, supplies, materials, drugs and professional services not contained in the CPT® coding system. These codes begin with a single letter, followed by four numbers (e.g., K0007).

HCPCS Level II modifiers are developed and updated annually by CMS and are used to indicate that a procedure has been altered. These modifiers consist of two letters (e.g., --AA) or one letter and one number (e.g., -E1).

Local codes are used to identify department unique services or supplies. They consist of four numbers followed by one letter (except F and T). For example, 1040M must be used to code completion of the department's accident report form. The department continually monitors national code assignments and will modify local code use as national codes become available.

Local modifiers are used to identify department unique alterations to services. They consist of one number and one letter (e.g., -1S). The department continually monitors national modifier assignments and will modify local modifier use as national modifiers become available.

REFERENCE GUIDE FOR CODES AND MODIFIERS

	HCPCS Level I			HCPCS Level II	
	CPT® Category I	CPT® Category II	CPT® Category III	HCPCS	L&I Unique Local Codes
Source	AMA/ CMS	AMA/ CMS	AMA/ CMS	CMS/ ADA	L&I
Code Format	5 numbers	4 numbers followed by F	4 numbers followed by T	1 letter followed by 4 numbers	4 numbers followed by 1 letter (not F or T)
Modifier Format	2 numbers	N/A	N/A	2 letters or 1 letter followed by 1 number	1 number followed by 1 letter
Purpose	Professional services, pathology and laboratory tests	Tracking codes to facilitate data collection for tracking performance measurement	Temporary codes for new and emerging technologies	Miscellaneous services, supplies, materials, drugs and professional services	L&I unique services, materials and supplies

CURRENT PROVIDER BULLETINS AND PROVIDER UPDATES

Provider Bulletins and Provider Updates are adjuncts to the *Medical Aid Rules and Fee Schedules* (MARFS), providing additional fee schedule, medical coverage decisions and policy information throughout the year.

Provider Bulletins give official notification of new or revised policies, programs and/or procedures that have not been previously published.

Provider Updates give official notification of contacts, corrections or important information, but the contents do not include new policies, programs and/or procedures.

Current Provider Bulletins and Provider Updates are available on the department's web site at <http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp>.

If a Provider Bulletin or Provider Update is not listed on the department's web site, it is either no longer available or has been incorporated into MARFS. Refer to the body of MARFS to locate changes affecting your practice.

